STATE OF VERMONT
AGENCY OF HUMAN SERVICES

P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N NO.: 03-17F

FROM: John Michael Hall, Commissioner
for the Secretary

DATE: October 27, 2003

SUBJECT: Changes to Health Care Assistance Programs, the General Assistance Program (GA), and Emergency Assistance Program (EA), Mandated by Act 66 of 2003: Making Appropriations for the Support of Government.

CHANGES ADOPTED EFFECTIVE 12/1/03

INSTRUCTIONS

_X_ Maintain Manual - See instructions below.

___ Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____

___ Information or Instructions - Retain until _____

MANUAL REFERENCE(S):

TOC M100	TOC M200	2602	TOC 3200	TOC 3300	TOC 4000
M100	M200.24	2620	3202 – 3202.1	3300	4001.91
M102	M231.23	2802	3202.3	3302	4002
M102.1	M232.98	2820	3203	3303.1	4003.1
M103.2	M233.24		3204	3305	
M103.3	M302.26			3402.8	
M112	M302.27				
M113	M670.3				
M143					
M150 – M150.2					

To sustain Vermont's public health care assistance programs, the FY04 appropriations act (Act 66 of 2003) of the Vermont General Assembly mandates cost-saving measures for health care programs administered by the department. These actions require amendments to the rules governing these programs. This bulletin contains those changes and clarifies related sections to be consistent with these measures.

Expedited Rulemaking Process

The Vermont Legislature authorized PATH in section 152a of Act 66 (2003) to adopt these rules using an expedited rulemaking process to ensure implementation by January 1, 2004. The provisions in this bulletin eliminating eyewear coverage and the 6-month guaranteed period as well as the provisions concerning appeal rights were promulgated previously, pursuant to expedited rulemaking process authorized in section 152 of Act 66, to ensure implementation by July 1, 2003. These previously promulgated rules expire by operation of law on December 31, 2003. They are repromulgated here as authorized by section 152a of Act 66.

Specific Changes to Existing Rules

Eyewear Coverage M103.2, M150.1, M670, 3300, 3305, 4003.1	Removes eyewear from the list of covered items, thereby continuing indefinitely the suspension of eyewear coverage for adults that began in July 2002. Eyewear includes eyeglass frames and lenses, contacts, and special lenses.
6-Month Guaranteed Coverage Period M100, 4002.32	M100 P.3 addressed only this guaranteed period so this page was deleted. Rule 4002.32 deletes all references to the 6-month guaranteed period. This change eliminates the guarantee of 6-months of coverage even if beneficiaries become ineligible during that time. This change affects beneficiaries enrolled in the managed care delivery system in the Medicaid and VHAP coverage groups.
Premiums M102, M102.1, M103.2, M103.3, M112, M113, M150, M150.1, M150.2, M200.24, M302.26, M302.27, 3202, 3203, 3204.1, 3204.3, 3204.4, 3302.1, 3302.3, 3302.4, 3303.1, 4001.91, 4002.3, 4002.31, 4002.4	Describes the eligibility and enrollment process for all health care assistance programs. Changes all existing program fees to premiums. Adjusts billing cycles making all premiums billed monthly and prospectively. Effective April 1, 2004, makes reenrollment possible if the department receives and processes the premium on the next business day following the last day of the month the premium was due. Effective April 1, 2004, provides for reenrollment without a new application in most instances when the department receives and processes the premium payment after the first business day after the month the premium was due, but within the first month after closure. Increases the premiums in the VHAP, Working People with Disabilities and Dr. Dynasaur coverage groups, including children covered under SCHIP. Requires payment of premiums for retroactive Medicaid coverage. Describes when medical incapacity establishes basis for retroactive coverage for VScript, VHAP-Pharmacy, and VHAP-Limited coverage. Clarifies the rule by including the premium for pregnant women in the Dr. Dynasaur coverage group with income between 185% and 200% FPL. Establishes premiums in the VHAP-Pharmacy, VScript, and VScript expanded coverage groups. The following charts summarize the changes:

Medicaid Coverage Groups				
Income	**Other Insurance?**	**Coverage Group**	**Monthly Premium**	
FPL			Old	New
> 185% ≤ 200%	Yes or No	pregnant women in Dr. Dynasaur	$20	$25
> 185% ≤ 225%	Yes or No	children under 18 in Dr. Dynasaur	$20	$25
		working people with disabilities	$20	$50
> 225% ≤ 250%	Yes	working people with disabilities	$24	$60
	No		$50	$75
> 225% ≤ 300%	Yes	children under 18 in Dr. Dynasaur	$24	$35
	No		$50	$70

VHAP Coverage Group		
Income	**Premium**	
FPL	Old - 6 Month	New - Monthly
> 50% ≤ 75%	$10	$10
> 75% ≤ 100%	$15	$35
> 100% ≤ 150%	$40	$45
> 150% ≤ 185%	$50	$65

Pharmacy Coverage Groups		
Income	**Coverage Group**	**New Monthly Premium**
FPL		
≤ 150%	VHAP-Pharmacy	$13
> 150% ≤ 175%	VScript	$17
> 175% ≤ 225%	VScript expanded	$35

Co-payments
M103.2, M103.3, M150.1, 3203, 3204.5, 3303.1, 4001.92,

Eliminates all co-payments and coinsurance in the VHAP coverage group, except the $25 co-payment for emergency room visits is maintained. Eliminates all co-payments, coinsurance and deductibles in the VHAP-Pharmacy, VScript, VScript expanded, and VHAP coverage groups.

Changes hospital co-payments in the Medicaid program. These co-payments do not apply to children, pregnant women, or residents of nursing homes. They apply only to beneficiaries age 18 or older receiving SSI-related Medicaid and beneficiaries 21 or older receiving ANFC-related Medicaid:

- For coverage groups in the managed care delivery system, a $3.00 co-payment is established for each outpatient visit, and a $75.00 co-payment for each inpatient admission.
- For coverage groups in the fee-for-service delivery system, the co-payment for outpatient visits remains at $3.00, and the co-payment for each inpatient admission increases from $50.00 to $75.00.

VHAP-Limited
4002.3, 4002.31, 4002.32

Redefines the enrollment period for VHAP limited coverage to be from the date that eligibility is determined to the date that full VHAP-managed care coverage begins, contingent upon receipt of premium payment. Full VHAP managed-care coverage begins the first of the month following payment of any required premium and selection or assignment of a primary care provider.

Appeal Rights
M143, 3204.5, 3302.6, 3402.8, 4002.6

The legislation also requires two changes to beneficiaries' right to appeal. The rule eliminates continued benefits for participants who appeal a mass change. It also requires beneficiaries to pay the premium as billed by the department for coverage to continue while their appeal is pending, even if the amount of the premium is the subject of the appeal. The department will reimburse beneficiaries who are successful on an appeal concerning the amount of their premium.

Savings Bonds
M231.23, M232.98, M233.24

The exclusion formerly at M232.98 has been removed and the page deleted. Specifies that United States savings bonds are a countable resource for SSI-related Medicaid and no longer considered unavailable during their minimum retention period. Savings bonds are not exempt from consideration as resources under the law. SSA §1613; 42 U.S.C. §1382b; 20 C.F.R. Subpart L §§416.1201-1266. Through Act 66 §147(k) (2003) the General Assembly has directed the department to count United States savings bonds as resources for SSI-related Medicaid.

GA and EA 2602 and 2620 2802 and 2820	Aligns GA and EA sections 2602 and 2802 and clarifies that applicants must pursue alternative ways to meet needs, including pursuit of government-sponsored health insurance. Adds denial or closure of government-sponsored insurance due to failure to pay a premium or fulfill any administrative requirement as a disqualification of eligibility for GA/EA medical need assistance. Adds definition of premium. Adds payment of premiums for government-sponsored health insurance to a list of costs not covered by GA/EA. With the approval of the Legislative Committee on Administrative Rules, the provisions related to premiums are effective on April 1, 2004.
Related clarifications 3202.1 3202.3 3305	Clarifies that chiropractic services are available to children under age 21 only; clarifies that copayments never apply to SSI-related Medicaid beneficiaries under age 18 and ANFC-related Medicaid beneficiaries under age 21; eliminates redundant text stating that pharmaceutical purchasing in the VScript coverage group mirrors Medicaid practices.

Summary of Public Hearing and Written Comments

A public hearing was held on September 22, 2003 at 1:00 p.m., in the Planning and Evaluation Division's Blue Room, Department of PATH, State Office Complex, Waterbury, Vermont. No member of the public attended. Written comments were submitted by the Health Care Ombudsman, the Community of Vermont Elders, the Vermont Coalition for Disability Rights, AARP Vermont, the Vermont Ombudsman Project, Disability Law Project, Senior Citizens Law Project, Vermont Legal Aid's Poverty Law Project, and an attorney with a private practice in Vermont.

On September 29, 2003, the department met with the parties who had submitted written comments for further discussion of the issues. The department has summarized and responded below to comments specific to regulatory issues in the section "Specific Comments and Responses" and the general operation of the premium system in the section, "General Responses to Other Comments."

Specific Comments and Responses

Copayments for SSI-related Medicaid recipients between age 18 and 21 (M103.2, M103.3, M150.1)

Comment: On what basis has the department mandated copayments for SSI-related Medicaid recipients between age 18 and 21?

Response: The department agrees that the proposed rule was too broad and has amended each of the three affected sections.

Appeal provisions (M143, 3204.5, 3302.6, 3402.8, 4002.6)

Comment: Is the department required to give beneficiaries 90 days from receipt of notice of action to appeal to the Human Services Board?

Response: Federal law requires states to give "a reasonable time not to exceed 90 days from the date that notice of action is mailed to request a hearing." 42 C.F.R. 431.221(d). The department has clarified the text in rule 3204.5 (replaced "made" with "mailed") to align with comparable provisions for other coverage groups.

Comment: The new appeals provision should state that benefits do not continue without change when the appeal is based *solely* on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries. 42 C.F.R. 435.230(a)(1).

Response: The department agrees that the provision would be more precise if "solely" were added. For greater clarity, the department has aligned the right to continued benefits provisions to read identically for all five coverage groups subject to this provision.

Comment: Does federal law authorize PATH to require payment of premiums pending appeal, when premium amount billed is alleged to be the result of a clerical or computational error?

Response: Act 66 mandates that the department's rules require beneficiaries to pay premiums at the "billed amount until the dispute is resolved." The department has added language to provide that it will reimburse beneficiaries who are successful on an appeal concerning the amount of their premium.

Comment: Federal law requires benefits to continue at the same level when a hearing is requested within 10 days of notice of action, until that issue is resolved at hearing. Therefore, beneficiaries should only be required to pay the original premium, not a higher amount.

Response: The department's rules comply with federal regulations that require services to remain at the same level when hearings are requested timely. 42 C.F.R. §431.230. Individuals are not prevented from receiving services; they are only precluded from getting them at the same cost. Vermont Act 66 §147(l)(2) (2003) addresses an issue not specified in federal law. As noted above, the department has added language to provide that it will reimburse beneficiaries who are successful on an appeal concerning the amount of their premium.

Comment: Rule M143 should be clarified so that Medicaid continues until a redetermination concludes an individual is not eligible and has had a chance to appeal.

Response: This part of the rule has not been substantively changed. The department ends Medicaid coverage only when individuals no longer pass the criteria for any one or more of the available coverage groups. Rule M133. The provision in the second to the last paragraph of rule M143 concerns individuals who have applied only for SSI/AABD and have never applied for Medicaid. The only way they are known to PATH is through the electronic interface PATH has with the Social Security Administration (SSA). Accordingly, an adverse SSI/AABD determination leads to closure.

Provisions related to retroactive coverage (M102, M113, M200.24(b), 4002.31)

Comment: Proposed rule M102 paragraph 3 is inconsistent with retroactive coverage provisions.

Response: The department has clarified the end of the paragraph to provide that coverage begins the first day of the month after the receipt of any required premiums, "unless retroactive coverage provisions described in rule M113 apply."

Comment: Retroactive coverage is federally required for working people with disabilities as a traditional Medicaid population. Attempts to limit this are inconsistent with federal law.

Response: Working people with disabilities is an optional categorically needy coverage group, not a mandatory one. Individuals are not prevented from receiving retroactive coverage; they are just precluded from obtaining it without cost. The department conditions retroactive coverage on payment of premiums because the statutory authority for working people with disabilities authorizes the state to impose requirements for "payment of premiums or other cost-sharing charges (set on a sliding scale based on income) . . . " 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII); SSA §1902(a)(10)(A)(ii)(XIII).

Comment: Please explain what "in whole or in part" means.

Response: This phrase has been eliminated from Rule 200.24(b) and now appears only in Rule 4002.31. It provides that the department will grant VHAP-limited coverage, when failure to pay a premium was a basis for the department canceling coverage and one of the five specified exceptions are also met.

Comment: The department has no legislative authority for inserting criteria after the first bullet of "terminated."

Response: In addition to the commissioner's general rulemaking authority conferred through 33 V.S.A. §105, the department received guidance from the Legislature last year through Act 142, §148(b) to adopt VHAP rules for individuals who lost their employer or university-sponsored insurance within the past 12 months. Rules M200.24(b) and 4002.31 have been revised to track Act 142 more clearly.

Impact of prospective premiums on automatic enrollment in other potential coverage groups (3204.1)

Comment: Applicants found ineligible for VHAP-Pharmacy or Medicaid should be automatically enrolled, not "offered enrollment" in VScript.

Response: The department cannot automatically enroll individuals in VScript because applicants with income above allowable limits for VHAP-Pharmacy or Medicaid will qualify for VScript only upon payment of any required premium. Also, since VScript premiums will be higher than those for VHAP-Pharmacy or Medicaid, automatic enrollment is not possible. The department has revised the sentence to provide that individuals found ineligible for VHAP-Pharmacy or Medicaid shall have their eligibility determined for VScript and "enrolled upon payment of required premium, provided all other eligibility criteria are met."

Comment: Please insert eligibility review language specified in VHAP-Pharmacy in rule 3302.3(A) into VScript 3204.3(A).

Response: The department has made this change.

Working People with Disabilities (M200.24(b))

Comment: Federal law prohibits limiting retroactive coverage for the traditional Medicaid population, which includes the working people with disabilities coverage group, when a recipient re-enrolls following nonpayment of a premium.

Response: After consultation with members of the House and Senate Appropriations Committees, and with the approval of the Legislative Committee on Administrative Rules, the department has deferred imposition of the additional requirements for retroactive coverage specified in Act 66. The final rule removes subsection three from rule M200.24(b) and amended M113 in order to make this change. Federal law authorizes states to determine premiums, including those for retroactive coverage, for this optional coverage group. The department relies on the statutory authority for working people with disabilities, which provides that the coverage group is subject to "payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine." 42 U.S.C. §1396a(a)(10)(A)(ii)(XIII); SSA §1902(a)(10)(A)(ii)(XIII).

As noted above, individuals are not prevented from receiving retroactive coverage; they are just precluded from obtaining it without cost. The regulation cited by the commenter, 42 C.F.R. §435.914, relates to retroactive coverage for all Medicaid coverage groups generally, and is not as specific as the federal statutory authority applicable to this particular optional coverage group. Moreover, the statute relied on by the commenter, 42 U.S.C. §1396a(a)(3), does not pertain to retroactive coverage.

Comment: Premiums charged working people with disabilities are unfair because they add more cost sharing than other coverage groups subject to premiums and do not take into account Medicare premiums the group from 185-225% FPL pays.

Response: As noted above in the previous response, the statute permits states to establish its own premiums and other cost-sharing charges. The Legislature established the premium levels for this coverage group. The department is not authorized to modify that structure and draw a distinction between individuals with income between 185-225% FPL who pay Medicare premiums and those who do not.

Comment: The legislative authority for barring retroactive coverage for working people with disabilities was inserted after conferees finished negotiations.

Response: The department is bound to follow the provisions of Act 66, as enacted.

Comment: The budget act specifically requires federal approval to implement the limitation on retroactive coverage for working people with disabilities.

Response: The department is submitting a state Medicaid plan amendment modifying its state plan pertaining to premiums for this coverage group. The department has already discussed and received approval of this proposed approach with the Technical Director for Medicaid Eligibility Policy in the Disabled and Elderly Health Programs Group of the Center for Medicaid and State Operations. It is expected to be approved before the implementation date of the rule.

Treatment of United States Savings Bonds (M233.24)

Comment: The department has no lawful basis for these regulations. The federal law relied upon by the department is not an exhaustive list of exclusions. Other federal law supports exclusion of savings bonds and preempts state law to the contrary. Bonds must be excluded from resources because they are not available. Individuals receiving SSI must be guaranteed Medicaid. Act 66 requires inclusion of a grandfathering provision.

Response: With the approval of the Legislative Committee on Administrative Rules, the department has revised this rule to include a grandfather provision. When determining financial eligibility for SSI-related Medicaid, Vermont follows the rules for the most closely related cash assistance group. 42 C.F.R. §435.601(b). The proposed rules are consonant with the law, regulations and function of the SSI program: to assure a minimum level of income for aged, blind and disabled people who do not have sufficient income and resources to maintain a standard of living at the established minimum level.

Definition of Medical Incapacity (3204.3, 3302.3, 4002.31)

Comment: PATH's proposed rules defined medical incapacity based on its understanding that the Legislature intended a narrow exception that would accommodate individuals who failed to pay premiums as a result of inpatient hospitalization or severe memory loss throughout the period premium payments were due. Several commenters have objected to the narrowness of the definition. They suggest medical incapacity should include problems that may not require hospitalization but may cause someone to miss a payment deadline. For example, moderate or slight memory loss, other forms of dementia or depression, infection, dehydration, chronic pain, changes in medication regimens, as well as availability and schedule of care givers, or even those whose forgetfulness or lack of understanding of the process caused nonpayment.

Response: With the approval of the Legislative Committee on Administrative Rules, the department has defined medical incapacity more broadly, specified this definition in section M150.1(A), cross-referenced it in each of the three rules that use this term, and clarified the three rules containing the cross-reference (3204.3(B), 3302.3(B), 4002.31(E)).

Comment: The Americans with Disabilities Act (ADA) requires that PATH's definition of medical incapacity not be limited only to those whose disability leaves them hospitalized or with severe memory loss throughout the period premium payments were due. It must accommodate individuals whose mental illness or developmental disabilities interfere with their ability to pay. It cannot provide benefits or services in ways that exclude people with disabilities or are less effective for them. 42 U.S.C. §12132. The department should enclose a "Declaration of Medical Incapacity Form" with all termination notices due to nonpayment of premiums. The form should allow recipients to sign it stating that their failure to pay the premium was the result of their medical incapacity. The form could include the regulatory definition of medical incapacity on the form. No other verification should be required.

Response: The department understands its obligations under the ADA and is engaged on an ongoing basis as individual circumstances require in making all of its programs as accessible to disabled individuals as possible and as the law requires. Rule 2170. The department is studying different procedural strategies for informing people about their rights regarding the impact of medical incapacity on their eligibility.

Comment: Rule M104 already allows for authorized representatives. The department should inform beneficiaries of the rule M104 option for authorized representatives but not require designation because Act 66 does not require it and individuals will not always be able to designate an authorized representative.

Response: To conform to Act 66, the department has amended the rule to make authorized representatives optional, rather than mandatory.

Comment: Must individuals agree to guardianship if they have a chronic condition that could intermittently interfere with ability to pay a premium?

Response: No. Although individuals with financial guardians may rely on the guardian to assist with paying bills, the department's rule does not require an authorized representative be a court appointed guardian.

Comment: The department must notify beneficiaries in pharmacy coverage groups of their right to pay premiums retroactively and have their coverage reinstated when they lose coverage for nonpayment of premiums because of medical incapacity.

Response: The department will include language to this effect on the closure notice for pharmacy programs.

General Assistance (GA) and Emergency Assistance (EA) Rules (GA 2602, EA 2802)

Comment: What is the agency's intent in adding the words "pursue and pursued" to GA 2602 and EA 2802? What does the agency mean by "explore and pursue all alternatives"? Who decides what alternatives are available? What kind of "proof" must the beneficiary provide to demonstrate that all alternatives have been explored and pursued? Exploring and pursuing all alternatives would suggest a lengthy process.

Response: The language "pursue" and "pursued" has been added to clarify that the term "explore" means that the applicant must actually try to acquire alternative means to meet the emergency need. This is not a substantive change. It clarifies the practice already in place. Both programs' rules specify that assistance under these programs be granted only when the need cannot be relieved without the department's intervention. GA rule 2600 and EA rule 2800A. The practical application of this requirement is that the applicant must first use other accessible resources to meet the emergency need.

In practice, district workers are familiar with community resources in their area and may contact another agency on behalf of a client. The rule requiring exploration of other resources applies to the workers as well as applicants. If all resources known to the worker have already been explored and are not available, the otherwise eligible applicant will receive EA or GA help with the emergency need. When circumstances do not allow for a timely determination of whether all other resources known to the worker and applicant have been pursued, the worker may provide assistance to meet the immediate emergency need and direct the applicant to pursue the other alternatives and bring proof of having done so before the applicant seeks more GA or EA for that particular need. Workers help applicants access other governmental and nongovernmental resources.

Comment: What is the meaning of the phrase "any administrative eligibility requirement necessary to be covered by the government-sponsored health insurance"?

Response: The phrase is intended to cover any administrative requirements for eligibility that the applicant must fulfill to access the benefit. Examples of administrative eligibility requirements include completing the application and providing information and documentation as required by rule.

Comment: Under what authority does PATH promulgate the rules at GA 2602 and EA 2802 making individuals ineligible for these programs if they have been denied or lost government-sponsored health insurance because they failed to pay their premiums or comply with administrative requirements?

Response: Authority for this rule comes from Act 66 section 147(g)(4)(A) and (B). This section requires the PATH commissioner to adopt rules to clarify that the general and emergency assistance programs do not cover payment of premiums for private or government-sponsored health insurance. Furthermore, they do not cover medical needs of applicants who are eligible for government-sponsored health insurance that would have been covered except when they do not have such coverage because of either or both of the following reasons: failure to pay a premium for government-sponsored health insurance; or failure to comply with any other administrative eligibility requirement for premium-based

government-sponsored health insurance. In addition, section 152a of Act 66, gives the PATH commissioner authority to adopt rules under an expedited rule-making process in order that changes authorized in Act 66, including subsection (g), can be implemented by January 1, 2004, or as soon as the rules are adopted.

Reach Up Rules (2351.41)

Comment: VCDR requests that PATH amend its Reach Up regulations at Reach Up Rule 2351.41 to permit payment for vision services for individuals no longer covered by public assistance programs because adequate vision is necessary for driving, education and employment.

Response: The department may propose rule changes by this expedited process only as specifically authorized by Act 66. Furthermore, the suggestion that PATH amend its Reach Up rules to expand services to include vision services for Reach Up participants and others no longer covered by public assistance programs would require an appropriation of general funds to provide the coverage. Currently, Reach Up rules are limited in application to Reach Up program participants and do not cover vision services. The rules specifically provide that PATH shall not pay for medical services using TANF funds. This prohibition derives from the general federal prohibition on using TANF funds for medical services at 42 U.S.C. §608(a)(6).

Additional Amendments to the Final Proposed Rule

The department has made the following additional changes since filing the proposed rule.

Proposed elimination of the $4 premium obligation for the VHAP coverage group (4001.91)

The department has proposed deferring the $4 premium for VHAP beneficiaries with income at or below 50 percent of the federal poverty level to the Health Access Oversight Committee. Per the direction of the Legislature in Act 66, section 147(g)(9), the department studied the impact of charging premiums for this group of individuals and recommended to the Health Access Oversight Committee of the Legislature that the provision would result in a substantial reduction in enrollment of at least 15 to 25 percent. The Health Access Oversight Committee approved deferral of this provision at their meeting on October 14, 2003. With the approval of the Legislative Committee on Administrative Rules, the final rule excludes the $4 premium requirement for VHAP beneficiaries with income at or below 50 percent of the federal poverty level.

Clarified reference to eyeglasses (M103.3 P.6)

The department has clarified the reference in rule M103.3 at page 6 to specify that every 24 months only children under age 21 may receive one routine eye exam and eyeglasses without a referral from their primary care provider.

Allowed Reenrollment without a new application (M112)

With the approval of the Legislative Committee on Administrative Rules, when individuals have been disenrolled from coverage solely for nonpayment of a premium, the department will permit automatic reenrollment without a new application and without an interruption of benefits if the premium is received and processed by the department on the first business day following the closure date.

In addition, when the only reason for closure is nonpayment of a premium and reinstatement is requested as indicated by receipt of payment of the outstanding premiums within the month following closure, the department will permit individuals or households to reenroll without completing a new application, unless the review date is the month following closure or the month thereafter. When the payment is received any day after the first business day in the month following closure, there will be an interruption of benefits and the most recent review period will be reestablished. If the review date is this month or next month, a new application will be required, and the premium payment will be credited to the individual's or the household's account.

The department's computer system (ACCESS) is currently programmed to send notices requiring a new application when a review is scheduled this month or the next month. The department will reprogram ACCESS to permit individuals to reenroll without completing a new application, unless a review is scheduled for this month or the next month. Premium payments credited to accounts of individuals in the month after closure will automatically be applied to the following month's coverage, following the effective date of coverage rules for new applicants.

Rules M112 and M150.1(B) have been amended to reflect these changes.

Clarified rules governing the operation of the premium system (M102.1, M150.1(A))

The department clarified two sections of the proposed rule to describe the operation of the new payment system more precisely, such as the automated same-day receipt and processing of payments.

General Responses to Other Comments

The proposed prospective premium payment system is a significant change in Vermont's health care assistance program. It has operational implications as well as regulatory ones. The proposed rules capture the essential obligations of the department and beneficiaries. Here is additional context for understanding these regulatory changes.

Phase-In Process of New Premium System

Act 66 directs the department to transition from a system with copayments to one with premiums as of January 1, 2004. The department will be in compliance with the statute as it will begin sending monthly bills in early December for all affected coverage groups. The department has serious concerns about moving too rapidly in the transition to a monthly, prospective premium environment. Accordingly, the department has determined it would be best to implement the attached rules effective December 1, 2003, with the following exceptions:

Section	Part of section effective April 1, 2004
M102	para. 3
M102.1	para. 1, sentence 1
M112	paras. 3, 4
M113	para. 1, sentence 1, billing retroactive premiums will be phased in
M150.1(A)	paras. 1, 2; and 3 only to the exent it is conditioned on prepaying the required premium

M150.1(B)	paras. 2, 4, 5, 6, 7
M200.24(b)(ii)	para. 1, to the extent coverage is conditioned on prepaying the required premium
M302.26	para. 2, to the extent it crossreferences provisions of M150 requiring initial coverage contingent upon payment
2602	para. 1, last sentence; para. 4; para. 5, sentence 1
2620	para. 2, to the extent coverage is conditioned on paying the required premium as a condition of 1. enrollment.
2802	para. 1, last sentence; subpara.graph (4) and first sentence of the following para.graph
3202	para. 1, to the extent coverage is conditioned on prepaying the required premium
3203	para. 1, to the extent coverage is conditioned on prepaying the required premium
3204.1	para. 3, to the extent coverage is conditioned on prepaying the required premium
3204.3(B)	para. 1, to the extent it crossreferences provisions of M150 that will be phased in and is conditioned on prepaying the required premium; paras. 3, 4
3302.3(B)	para. 1, to the extent it crossreferences provisions of M150 that will be phased in and is conditioned on prepaying the required premium; paras. 3, 4
3303.1	para. 1, to the extent it crossreferences provisions of M150 that will be phased in
4001.91	para. 1, to the extent it crossreferences provisions of M150 that will be phased in
4002.3(B)	para. 1
4002.31	entire section phased in, except sentence 1
4002.32	entire section phased in

The sections of the rules listed above will not be operationalized until April 1, 2004. This will enable smoother implementation. The phase-in will ensure the department's ability to provide a high quality program with adequate testing and more beneficiary-friendly components. This phased-in process is also likely to mitigate disenrollment due to nonpayment of premiums.

Premium Operational System

Comment: How will the department manage the payment process, including receipt and processing of premiums?

Response: A premium will be considered received and processed when posted on the department's ACCESS eligibility system. This occurs electronically the evening of the day the bank, which is located in Williston, receives the payment. This does not preclude the department from terminating coverage if it subsequently learns that the payment did not clear.

In response to commenters' concerns about payments made by ongoing beneficiaries at the very end of the month, the department will deem a premium paid if received and processed by the first business day of the month following the premium due date. In those instances, beneficiaries will be reenrolled retroactive to the first of the month the premium covers. Beneficiaries will receive a notice when reenrollment occurs and may call Member Services to check on the status of their coverage. Providers will verify eligibility as they currently do. This procedure balances expedited reenrollment with preservation of the existing sequence o

required notice and closure for nonpayment which is necessary given that the department cannot presume that a payment will arrive.

The department recognizes that the monthly premium system is a new process for beneficiaries that will be a financial burden to some and confusing to others. The department also recognizes its obligation under Act 66, §147(g)(2) to implement the new premium system "as soon as administratively feasible." The department is focusing its limited resources on the essential issues related to the many complexities needed to transition to this new premium system: eligibility processing, clear notices, as well as bill creation and receipt.

The department fully intends to explore and implement alternate payment methods once the basic framework of the new system is operationalized. In the interim, the department has made two accommodations. One is related to the receipt of late payments on the first business day of the next month, as described above. The other is easing the current requirement that beneficiaries complete a new application. When there is less than a one-month gap in coverage between the closure for nonpayment and receipt of the premium a one month grace period will allow beneficiaries to be reenrolled upon payment of the premium without completing a new application unless a review is scheduled for this month or the next month. An additional payment option
already available to beneficiaries is to elect an authorized representative to receive monthly premium bills or other notices, including the delinquency and closure notices.

Comment: How will the department manage partial payment of premiums?

Response: After assessing billing options, the department chose to send one bill to each of the approximately 35,000 households (42,000 premiums) subject to premiums. Approximately 80 percent of these households are responsible for one premium. Sending a combined bill for the remaining 20 percent of the households enables the department to save costs related to producing and mailing an additional 7,000 individual monthly bills. Each combined bill will list the itemized premium amounts for each coverage group in the household.

The department believes that this approach will be easier and less confusing for most households, enabling them to pay with one coupon and one check. Recognizing that some households with multiple coverage groups will not be able to pay the total amount due, bills will include the following language in two places: "If you cannot pay the total amount for all programs or individuals, please call Member Services at 1-800-250-8427 (TTY 1-888-834-7898)."

Member Services will explain the option of partial payments and record the beneficiary's choice. Coverage will continue for those designated for the premium payment and end for those whose premium is not paid in full. The department is willing to reconsider this approach after six months if experience warrants and evaluate alternative mechanisms available to capture this information (e.g., individual bills, coupons, or check off boxes on the bill).

Comment: How will the department give notice of termination of coverage because of nonpayment of premiums?

Response: Approximately five days following the due date (the 15th of the month), the department will send the required 11-day notice specifying that coverage terminates at the end of the month in which the bill was owed, since the premium was not paid in full by the due date. If payment is received before the effective date of closure, coverage will be reinstated and a notice of action sent confirming reinstatement. As noted above, beneficiaries also may call Member Services to check the status of their coverage.
Although several commenters suggested at the meeting on September 29th that the department send a second closure notice confirming termination of coverage, the department has chosen to limit notification to one closure notice. The department will consider adding clarifying information to the closure notice if commenters feel that would be helpful.

Comment: Please explain the refund process in more detail.

Response: Premiums are nonrefundable. Act 66, § 147(g)(5). Rules at M150.1 allow the department to reimburse the beneficiary when there is an overpayment, however. Overpayments may occur when the household pays the premium and then loses coverage before the period the premium covers (e.g., premium paid on March 5, income changes, or review forms are not submitted, or person dies, and case closes March 31). An overpayment may also occur due to a department error or late processing of a reported change. The reimbursement will be made automatically after 30 days.

In recognition that holding the reimbursement for 30 days will be a hardship for some, the department included the financial hardship provision. The final proposed rule moved this provision to the last paragraph in M150.1(A). Several commenters suggested immediate reimbursement rather than a credit for those who remain in a premium-based program. The department believes this is an extra administrative burden for the department as well as the beneficiary, given the short timeframe between bills and the likelihood that many of the households will reapply for coverage. The department will assess the possibility of making some reimbursement available automatically before the 30-day period when the likelihood of a reinstatement or reapplication is minimal or other circumstances warrant a quicker response.

Comment: How will the department bill premiums to accommodate income and household composition fluctuations and changes in coverage groups?

Response: Premium amounts are based prospectively on the information available for the month of coverage at the time the bill is produced. Households have 10 days to report changes in their situation and the department has 10 days to act on these changes. If a reported change results in a different premium amount within the same coverage groups, it will be reflected on the next bill. If a person changes coverage groups, a supplemental bill may be necessary. If an overpayment has occurred, a credit will be applied to the next monthly bill. Several variations on changes exist and the department is examining these implications, working to develop the most consistent and equitable procedures, and mindful that the new system is based upon a prospective approach. In some situations, as

is the case now, a new application may be required since all required information will not be on file.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

For more information about the Administrative Procedures Act and the rules applicable to state rulemaking go to the website of the Office of the Vermont Secretary of State at: http://vermont-archives.org/apa/rules.html or call Louise Corliss at 828-2863.

For information on upcoming hearings before the Legislative Committee on Administrative Rules go to the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedule/schedule2.cfm or call 828-5760.

Manual Maintenance

Medicaid Rules

Remove		Insert	
TOC P.1 & P.2 (M100-M199)	(02-33)	TOC P.1 – P.3 (M100-M199)	(03-17)
M102	(99-15)	M102	(03-17)
M102.1	(03-10)	M102.1	(03-17)
M103.2 P.3	(03-10)	M103.2 P.3	(03-17)
M103. 3 P.6	(01-18)	M103.3 P.6	(03-17)
M103.3 P.7	(03-10)	M103.3 P.7	(03-17)
M103.3 P.8	(99-8F)	M103.3 P.8	(03-17)
M103.3 P.9	(99-8F)	M103.3 P.9	(03-17)
M103.3 P.10	(99-8F)	M103.3 P.10	(03-17)
M103.3 P.11	(99-8F)	M103.3 P.11	(03-17)
M103.3 P.12	(99-8F)	M103.3 P.12	(03-17)
M111	(94-2F)	M111	(03-17)
Nothing		M113	(03-17)
M142.1 P.2	(03-10)	M142.1 P.2	(03-17)
M150	(03-10)	M150	(03-17)
M150.1 P.2	(03-10)	M150.1 P.2	(03-17)
Nothing		M150.1 P.3	(03-17)
Nothing		M150.1. P.4	(03-17)
Nothing		M150.1. P.5	(03-17)
M150.2	(92-1)	M151	(03-17)
TOC P.4 (M200)	(02-11)	TOC P.4 (M200)	(03-17)
M200.24	(02-11)	M200.24	(03-17)
Nothing		M200.24 P.2	(03-17)
M231.22	(02-11)	M231.22	(03-17)
M231.33	(02-11)	M231.3	(03-17)
Nothing		M233.24	(03-17)
M302.22	(01-07F)	M302.22	(03-17)
M302.26 P.2	(01-07F)	M302.26	(03-17)
Nothing		M302.27	(03-17)
M670	(03-10)	M670	(03-17)

General Assistance Rules

2602	(02-10F)	2602	(03-17)
2620	(02-10F)	2620	(03-17)

Emergency Assistance Rules

2801 P.3	(95-5F)	2801 P.3	(03-17)
2802 P.2	(95-5F)	2802 P.2	(03-17)
2820	(95-5F)	2820	(03-17)

VScript Rules

TOC (3200) P.1	(02-22)	TOC (3200) P.1	(03-17)
3202	(99-24)	3202	(03-17)
3202.2	(92-37F)	3202.2	(03-17)
3203	(02-22)	3203	(03-17)
3204	(97-4F)	3204	(03-17)
3204.3 P.2	(03-10)	3204.3	(03-17)
Nothing		3204.3 P.2	(03-17)
3204.5	(03-10)	3204.3 P.3	(03-17)

VHAP-Pharmacy Rules

TOC 3300	(96-4F)	TOC 3300	(03-17)
3300	(03-10)	3300	(03-17)
3302.1	(97-4F)	3302.1	(03-17)
3302.2 P.2	(97-4F)	3302.3	(03-17)
3302.5	(03-10)	3302.3 P.2	(03-17)
Nothing		3302.6	(03-17)
3303.1 P.2	(02-22)	3303.1 P.2	(03-17)
3305 P.2	(03-10)	3305 P.2	(03-17)

Healthy Vermonters Rules

3402.5	(03-10)	3402.5	(03-17)
Nothing		3402.8 P.2	(03-17)
3402.9	(02-18)	Nothing	

VHAP Rules

TOC (4000)	(96-45F)	TOC (4000)	(03-17)
4001.91	(01-07)	4001.91	(03-17)
4002.3	(03-10)	4002.3	(03-17)
Nothing		4002.3 P.2	(03-17)
4002.31 P.2	(03-10)	4002.31 P.2	(03-17)
4002.4	(03-10)	4002.5	(03-17)
4002.6 P.2	(03-10)	4002.6	(03-17)
4003.1	(03-10)	4003.1	(03-17)

M102 Eligibility and Enrollment Process

The eligibility and enrollment process includes the steps an individual requesting health care assistance and the department must take to determine an individual's eligibility for and enrollment in health care assistance programs.

Eligible means the department has decided the individual meets all the eligibility criteria specific to the coverage group such as age, residency, and income level.

Enrolled means *the department has received full payment of required premiums for* the individual who has been determined to meet all eligibility criteria specific to the coverage group. Enrolled individuals are health care assistance beneficiaries. Coverage begins the first day of the month *after receipt of any required premiums,* unless retroactive coverage provisions apply as in rule M113.

The person (or group) must:

- apply for health care assistance,
- give necessary facts about their (or their family's) situation for the eligibility tests, and
- pay any required premium by the due date.

The department must:

- accept all health care assistance applications and premium payments,
- compare the facts of the individual's situation to the health care assistance eligibility rules,
- make decisions on initial and continuing eligibility for health care assistance,
- notify the individual of its decisions, and
- keep records of decisions and the facts used to make them.

Rules and time limits for these steps are given in M110-M149.

M102 Eligibility and Enrollment Process

M102.1 Premiums

Certain health care assistance groups are required to pay a monthly premium as a condition of *initial and* continuing coverage. The amount of the premium depends on the net income of the assistance group on the most recent approved version of eligibility on the case record at the time the bill is generated, and for some coverage groups, the existence of other insurance that includes both hospital and physician coverage.

Failure to pay the full premium by the last day of the month shall result in disenrollment.

The premium payment system is described in M150 through M150.2.

M103 Benefit Delivery Systems

M103.2 Managed Health Care Plan System (Continued)

B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (M755);
- dental care for children under age 21 (M620) and limited dental services for adults up to the annual benefit maximum (M621);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (M670);
- chiropractic services for children under age 21 (M640);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (M740); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (M810-M812).

C. Cost Sharing

ANFC-related Medicaid beneficiaries age 21 and older and SSI-related Medicaid beneficiaries age 18 and older enrolled in a managed health care plan are subject to the following copayment requirements, unless exempt under M150.1(B):

- $75.00 for the first day of an inpatient hospital stay in a general hospital.
- $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.

Medicaid beneficiaries age 21 and older enrolled in a managed health care plan are subject to the following copayment requirements, unless exempt under M150.1(B):

- $3.00 for each dental visit.
- Prescriptions:
    - $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less;
    - $2.00 for each prescription, original or refill, having a usual and customary charge of more than $30.00 but less than $50.00;
    - $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program (Continued)

C. Services Requiring a PCP's Referral

The following services must be accessed through the beneficiary's PCP and are subject to the department's prior authorization requirements. Services requiring prior authorization are found in the Provider Manual. (Medicaid regulatory citations are indicated where applicable):

- inpatient services (M510);
- outpatient services in a general hospital or ambulatory surgical center (M520);
- physician services (M600-M618);
- specialty medical and surgical services of a dentist (M619);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (M613);
- home health care (M710);
- hospice services by a Medicare-certified hospice provider (M715);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (M520, M710);
- medical equipment and supplies (M830, M840);
- skilled nursing facility services (M900);
- podiatry services (M630);

D. Self-Referral Services

The following services may be accessed by beneficiaries without a referral from their primary care provider (PCP):

- unlimited visits per calendar year to a PCCM gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- mental health and chemical dependency visits up to benefits of $500 per year. Thereafter, providers must request prior authorization from the department for additional services;
- mental health and chemical dependency services provided by a community mental health center;
- Community Rehabilitation and Treatment Services (CRT);
- one routine eye examination every 24 months (M670) and eyeglasses for children under age 21 furnished through the department's sole source contractor (M670);
- transportation services (M755);
- emergency services(M106.4);
- dental care for children under age 21 (M620) and limited dental services for adults up to an annual benefit maximum (M621);

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

D. Self-Referral Services (Continued)

- chiropractic services for children under age 21 (M640);
- maternity/prenatal (M510, M600);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (M740).

E. Cost Sharing

ANFC-related Medicaid beneficiaries age 21 and older and SSI-related Medicaid beneficiaries age 18 and older enrolled in a PCCM are subject to the following copayment requirements, unless exempt under M150.1(B):

- $75.00 for the first day of an inpatient hospital stay in a general hospital.
- $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.

Medicaid beneficiaries age 21 and older enrolled in a PCCM are subject to the following copayment requirements, unless exempt under M150.1(B):

- $3.00 for each dental visit.
- Prescriptions:
  - $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less;
  - $2.00 for each prescription, original or refill, having a usual and customary charge of more than $30.00 but less than $50.00;
  - $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

F. Enrollment

1. Choice of Primary Care Provider (PCP)

A benefits counselor will assist beneficiaries in making an informed decision among the choices described in M103, Options 5 and 6.

The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision and will provide additional information if requested to do so. If two or more PCCM PCPs are available and no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a PCP using a state-approved algorithm.

2. Change of Primary Care Provider (PCP)

Enrollees may change their primary care provider (PCP) for any reason every 30 days. Primary care provider changes will become effective on the first day of the following month, if all required actions have been completed by the fifteenth of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

If a beneficiary has to change PCP as a result of his or her PCP restricting or terminating participation in the PCCM program, the department will assist the beneficiary in selecting another PCP in order to assure continuity of care.

3. Disenrollment

The department has sole authority for disenrolling beneficiaries from the PCCM program. The department may disenroll beneficiaries from the PCCM program for any of the following reasons:

- The beneficiary loses Medicaid eligibility;
- The beneficiary fails to pay required premiums;
- The beneficiary is placed in a nursing facility or ICF-MR for more than thirty (30) days, enrolls in any other state waiver program, enrolls in the department's "High Tech Home Care" program, or enrolls in Medicare or other comprehensive health insurance plan;
- The beneficiary's change of residence places him or her outside the area where choice of PCCM provider is available, and the beneficiary chooses not to continue enrollment in the PCCM program;

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

3. Disenrollment (Continued)

- The department has found that there is a rational and justifiable reason for determining that good cause exists, or upon appeal, the Human Services Board finds good cause exists, as the result of a formal request for disenrollment filed by the beneficiary;
- The department has found that there is a rational and justifiable reason for determining that good cause for disenrollment or transfer to another PCCM provider exists, as the result of a formal request for disenrollment filed with the department by the beneficiary's PCP;
- The department has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists; or
- The beneficiary poses a threat to PCCM providers, staff or other beneficiaries.
- The beneficiary regularly fails to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by his or her PCP; and
- The beneficiary does not cooperate with treatment and has not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by their PCP.

Grounds for disenrollment do not include beneficiaries who have cooperated with their PCP in his/her effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

The beneficiary will remain enrolled in the PCCM program until the department decides to disenroll or continue the enrollment of the beneficiary. Each beneficiary will be notified of the department's decision in writing and of his/her right to request a fair hearing before the Human Services Board. Beneficiary disenrollments will become effective on an end-of-month basis, but not fewer than five (5) days after the department has made a determination that the beneficiary will be disenrolled.

Individuals who are disenrolled, unless enrolled in a managed health care plan immediately thereafter, will receive services through the fee-for-service system.

4. Conversion of Managed Care Plan Enrollees to the PCCM program

If a beneficiary's delivery system is changed from a commercial managed care plan to the PCCM program, the beneficiary will be assigned to his or her existing PCP. Thereafter, the beneficiary may change his or her PCP according to the provisions of M103.3 F.2.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

4. Conversion of Managed Care Plan Enrollees to the PCCM program (Continued)

If the managed care plan member's PCP does not participate as a PCP in the PCCM program, the beneficiary will receive covered benefits in the fee-for-service system. The beneficiary's subsequent enrollment in the PCCM program will be deferred for at least six months beyond the date of disenrollment from the managed care plan. The department will make every effort to enroll the beneficiary's provider in the PCCM program prior to the expiration of the enrollment deferral period.

G. Quality Assurance and Utilization Review

1. The department shall ensure that health care services provided to its beneficiaries are consistent with prevailing professionally-recognized standards of medical practice. To that end, the department shall establish and implement procedures ensuring the availability of, accessibility to and continuity of care for each beneficiary consistent with the beneficiary's clinical condition, including procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in their administration and delivery of health care services.
2. The department shall develop and maintain an internal quality assurance program that monitors and evaluates the full range of its health care services across all institutional and noninstitutional settings. The quality assurance program shall be fully described in writing and provided to all administrative and clinical staff of the department, and made available to all providers upon request. A summary of the program shall be provided to anyone upon request.
3. The department's quality assurance and utilization management program shall ensure that in making decisions to approve or deny care, it uses not only utilization review standards and guidelines but also clinical case data, information and practice guidelines so as to balance the clinical decision-making process with its cost-containment measures.
4. The department shall have in place the administrative structures, policies, and procedures necessary to support operations that meet the requirements and criteria contained in these rules.
5. The department shall clearly define the organizational relationships and responsibilities for quality assurance functions and assign them to appropriately qualified individuals.
6. The department shall establish effective procedures to develop, compile, and evaluate the statistical and other information necessary to support an effective quality assurance and utilization management program.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

G. Quality Assurance and Utilization Review (Continued)

7. The department's quality assurance program shall include, but not be limited to, the following components:

a) A designated committee that is responsible for the department's quality assurance activities. The committee shall include, but not be limited to, at least one beneficiary in the PCCM program and participating providers.
b) Accountability of the designated committee to the commissioner of the department through the medical director.
c) Participation in the quality assurance program by the appropriate providers, support staff and beneficiaries. At a minimum, this shall include all PCPs, unless good cause is shown why they should not participate. The department shall establish programs to periodically train such providers, support staff and members to participate meaningfully in the quality assurance program.
d) Supervision of the quality assurance program by the medical director of the department, who shall be a physician licensed in Vermont.
e) Regularly-scheduled meetings of the designated committee.
f) Minutes or records of the meetings of the designated committee that describe, in detail, the committee's actions, including the problems discussed, recommendations made and any other pertinent information.

H. Quality Management and Improvement

1. The department shall establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement.
2. The medical director shall have primary responsibility for the quality assessment and quality improvement activities required of, and carried out by or on behalf of, the department. The medical director shall approve the written quality assessment and quality improvement programs and shall periodically review and revise the program documents and act to ensure their ongoing appropriateness.
3. The department shall use the findings generated by the system to work, on a continuing basis, with network providers and other staff to improve the health care delivered to its beneficiaries.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

H. Quality Management and Improvement (Continued)

4. The department shall develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in its quality improvement program, which shall be under the direction of its medical director. The organizational program shall include:

(a) A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities and an annual effectiveness review of the quality improvement program.

(b) An annual written quality improvement plan that describes how the department intends to:

(i) analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

(ii) identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the department shall consider practices and diagnoses that affect a substantial number of its beneficiaries or that could place beneficiaries at serious risk. This section shall not be construed to require the department to review every disease, illness and condition that may affect a beneficiary;

(iii) use a range of appropriate methods to analyze quality, including:

i) collecting and analyzing information on over-utilization and under-utilization of services, high-volume and high-risk services, and the continuity and coordination of care for acute and chronically-ill populations;

ii) evaluating courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases such as current medical research, knowledge, standards and practice guidelines; and

iii) collecting and analyzing information specific to a beneficiary or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of beneficiaries;

(iv) compare program findings with past performance, as appropriate, and with internal goals and external standards, where available, adopted by the department;

M110-M119 Application

M111 Application Requirement

Any individual who wants Medicaid must file a Medicaid application with the department except:
An individual who has applied at a Social Security Office for supplemental security income.

If an individual granted SSI/AABD also wants retroactive Medicaid coverage before the start of the cash assistance grant, he/she must file a separate application for retroactive Medicaid coverage and be found eligible based on criteria other than receiving cash assistance.

Filing an application means taking or mailing a signed Medicaid application form to a department office, preferably the district office responsible for the town where the applicant lives. Department offices give Medicaid application forms to any individual who asks for one. Medicaid providers, referring agencies and other locations serving the public may also keep supplies of application forms.

An application form must be signed by individuals applying for Medicaid or by their authorized representative.

M112 Reapplication and Reenrollment

Any individual who has applied before for Medicaid and is not now eligible for coverage may reapply at any time.

To reapply, the individual (or group) must file a new up-to-date signed application form with the department. An authorized representative may act for the individual or group when needed.

When an individual has been disenrolled from coverage solely for non-payment of a premium, if the department receives and processes the payment on the next business day following the last day of the month the premium was due, the coverage group will be automatically reenrolled without a new application and without a break in benefits.

If the department receives and processes the payment after the first business day after the month the premium was due, but within the first month after closure, the coverage group will be automatically reenrolled for the next month with a one month break in coverage. Beneficiaries must submit a new application, however, if any change in a coverage group's circumstances affects its eligibility, or a review of the case is scheduled for the current month or the following month.

M110-M119 Application

M113 Retroactive Application

Medicaid may be granted retroactively for up to three calendar months before the month of application provided all eligibility criteria were met during the retroactive period *and any premiums required for those months have been received by the department.* A woman is not eligible for the 60-day post-pregnancy period (i.e., when no other categorical criterion is met) if she was granted retroactively after her pregnancy has ended.

An authorized representative may apply for retroactive coverage on behalf of an individual who dies before he or she can apply for Medicaid.

Payments for Medicare cost sharing for individuals who are Qualified Medicare Beneficiaries (QMBs) and not otherwise eligible for Medicaid are first made in the month following the month QMB eligibility is determined. There is no retroactive QMB coverage.

Payments for Medicare cost sharing for the other Medicare cost-sharing groups can be paid for allowed Medicare costs incurred prior to the month of application provided all eligibility criteria were met during the three month retroactive period.

M142.1 Disability Determination Appeal (Continued)

(2) Department Disability Decision - if the state's disability determination agent has made a Medicaid disability determination under the circumstances specified in Determination of Disability or Blindness, the decision may be appealed to the Human Services Board.

M143 Continued Benefits During Appeal

When beneficiaries appeal a decision to end or reduce Medicaid coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary requests a hearing before the effective date of the adverse action and has paid in full any required premiums. If the last day before the adverse action date is on a weekend or holiday, the beneficiary has until the end of the first subsequent working day to request the hearing. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who are successful on an appeal concerning the amount of their premium will be reimbursed by the department for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

The department is allowed to recover the value of any benefits paid during the appeal period when the beneficiary withdraws the appeal before a fair hearing decision is made, or the reason for the appeal is an issue of law or policy and the Department's position is affirmed by the fair hearing decision

An issue of law or policy means that the person is questioning the legality of a law or rule rather than the facts used or department's judgment in applying the rules to make the decision being appealed.

When SSI/AABD beneficiaries are determined "not disabled" by the Social Security Administration (SSA) and appeal this determination, their Medicaid coverage continues as long as their SSI/AABD benefits are continued (or could have been continued but the client chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid coverage ends unless they apply and is found eligible for Medicaid on the basis of a categorical factor other than disability.

When Medicaid beneficiaries apply for SSI/AABD and are determined "not disabled" by the Social Security Administration (SSA) and file a timely appeal of this determination with the SSA, their Medicaid coverage continues until a final decision is made on the appeal provided the SSA's determination of "not disabled" is the only basis on which they might be found ineligible for Medicaid. If they continue to appeal unfavorable decisions by SSA, the "final decision" is made by the SSA Appeals Council.

M150 Payment System

The Vermont legislature instituted a premium-based payment system for most health care assistance programs with the 2004 Appropriations Act, Act 66 of 2003. This legislation also unified the method of billing and the premium collection system for all coverage groups.

M150.1 Cost Sharing Requirements

A. Definitions

(1) *Medical incapacity means a serious physical or mental infirmity to the health of the adult beneficiary or beneficiaries responsible for paying the premium that prevented the adult beneficiary or beneficiaries from paying the premium timely, as verified in a physician's certificate furnished to the department. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, providing the certificate is in fact received within seven days.*

(2) *Physician's certificate means a written statement on a form supplied by the department signed by a duly licensed physician certifying that an adult beneficiary suffered from medical incapacity that prevented the beneficiary from paying the premium timely. If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.*

(3) Premium means a nonrefundable charge as a condition of initial and ongoing enrollment received in full by the department from applicants.

(4) "Received" or "received and processed" means the department has posted the full premium payment and logged the transaction on the applicable case record on the department's computer system, thereby ensuring the information is available to authorized staff.

M150 Payment System

M150.1 Cost Sharing Requirements (Continued)

B. Premium

This section describes the general premium rules and process. Additional rules applicable to the specific coverage groups subject to these premium rules vary, and are described in the following sections: Working People with Disabilities (M200.24 (b)), Dr. Dynasaur (M302.26 and M302.27), VHAP (4000), VHAP-Pharmacy (3300), and VScript (3200).

Coverage always begins on the first day of a month *and only after the full premium has been received. Beneficiaries must pay the full monthly premium before coverage will begin, even if the department finds them eligible in all other respects before the first day of the next month. Applicants for Dr. Dynasaur and Working People with Disabilities may also be granted coverage during the months of application and billing provided all eligibility criteria were met during those months and the department has received and processed any premiums required for those months. They may also be granted retroactive coverage provided the requirements specified in M113 are met.*

The department's premium billing cycle is designed to make it as easy as possible for beneficiaries to maintain their monthly premium payments and avoid loss of coverage. The department's automated premium collection and distribution system manages the receipt and processing on the day of receipt of premiums if paid according to the billing directions.

The department will:

- send premium bills at least 25 days before the last day of the month, which is the date that coverage will end if the department does not receive the payment;
- mail beneficiaries a notice of impending closure at least 11 days before coverage ends for nonpayment of a premium;
- reinstate coverage without a break in benefits if the department receives the payment by the last day of the month, *or the first business day following the last day of the month in which the due date falls.*

When households with more than one coverage group make a partial payment of a bill that includes more than one premium, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of all of the billed premiums. Beneficiaries who want to choose which premium to pay must call the Member Services number on the bill to record that designation on the case record.

***Italicized* text on this page becomes effective April 1, 2004.**

M150 Payment System

M150.1 Cost Sharing Requirements (Continued)

In the event the beneficiary has not made the designation, the department will apply the partial payment to the following coverage groups in the following order: (1) Dr. Dynasaur; (2) Working People with Disabilities; (3) VHAP; (4) VHAP-Pharmacy; and (5) VScript. If there is more than one beneficiary in the same coverage group with the same premium amount, the department will apply the partial payment to the first beneficiary listed on the bill.

In the event of an overpayment, the department will retain and reflect it as a credit on the next premium bill. When coverage ends, to expedite a possible reinstatement if requested, the department will wait 30 days before reimbursing a beneficiary any credit remaining on the account. If coverage remains closed for 30 days, PATH will issue a refund within 10 business days thereafter. If it will be a financial hardship to apply an overpayment in this way, beneficiaries may request that the department reimburse the overpayment within 30 days.

The department will automatically reimburse a beneficiary the amount of a premium within 30 days from when coverage terminates before the month the premium pays for because the beneficiary:

- *moves out of state;*
- *moves from a premium-based coverage group to a non-premium-based group;*
- *becomes ineligible because of an increase of income; or*
- *dies.*

In addition to premiums, health care beneficiaries may also be responsible for copayments for some services, which are described below.

***Italicized* text on this page becomes effective April 1, 2004.**

M150 Payment System

M150.1 Cost Sharing Requirements (Continued)

C. Copayments

Copayments from some beneficiaries are required for certain services. Copayments will be deducted from the Medicaid payment for each service subject to copayment. Section 1916(c) of the Social Security Act requires that "no provider participating under the State (Medicaid) plan may deny care of services to an individual eligible for (Medicaid) . . . on account of such individual's inability to pay (the copayment)." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of (the copayment)."

Copayments are never required from beneficiaries who are:

- long-term care beneficiaries; or
- SSI-related Medicaid beneficiaries under age 18; or
- ANFC-related Medicaid beneficiaries under age 21; or
- pregnant or in the 60-day post-pregnancy period.

Copayments are required for these services:

1. $75.00 for the first day of an inpatient hospital stay in a general hospital.

2. $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.

3. Prescriptions for recipients age 21 and older as follows:

   - $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less,
   - $2.00 for each prescription, original or refill, having a usual and customary charge of $30.00 or more.
   - $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

4. $3.00 per date of service per provider for dental services for recipients age 21 and older.

M150 Payment System

M150.1 Cost Sharing Requirements (Continued)

No copayments are required for the following services:

1. Services reimbursed by the Department of Developmental and Mental Health Services.

2. Emergency hospital services.

3. Home Health, Hospice, and Home and Community Based Services for the Elderly and Disabled.

4. Services provided by other licensed practitioners including:

- Podiatry
- Audiology
- Psychological
- Optometric and Optician
- Nurse practitioner

5. Services provided by rural health clinics and federally qualified health care facilities.

6. Independent laboratory.

7. X-ray interpretations performed by a physician who has no direct contact with the beneficiary.

8. Transportation including ambulance.

9. Medical supplies.

10. Durable Medical Equipment (DME) purchases and rental and nursing services.

11. Oxygen and respiratory equipment and supplies.

12. Family planning services.

The department is not responsible for copayments a provider may collect in error or a beneficiary makes on a service that is not paid for by Medicaid.

M150.2 Obligation of the Department

The department will assure that mechanisms exist for the payment of reimbursable expenses.

M151 Eligibility Expenses

The department will pay the reasonable charge for any professional examination and report necessary to make a decision, or appeal a decision, on medical factors of blindness, disability or incapacity.

To receive payment, the examiner must submit the required report and an itemized bill for services necessary to complete the report.

M152 Medical Services

The department pays providers for Medicaid Services through a fiscal agent. To receive payment, the provider must send a claim to the fiscal agent subject to the limitations and conditions specified in Sections Ml54-Ml59.

The department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:

- The recipient applied for benefits after February 15, 1973, and was denied; and
- The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal).

Reimbursement is for 100 percent of the out-of-pocket expenditures made by a recipient or a member of his/her Medicaid group or a financially responsible relative who is not a member of the group, for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed). No copayment is due.

Payment cannot otherwise be made direct to a Medicaid recipient, even if he/she has already paid the provider for a covered service. When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the recipient's payment (see also Provider Responsibility).

The fiscal agent sends a notice of Medicaid benefits paid to a sample of recipients who receive a service each month. The recipient must report any disagreement with the notice to the department.

M200.2 SSI-Related Categorically Needy Coverage Groups (Continued)

M200.24 SSI-Related Medicaid Coverage Groups Open to New Aged, Blind, or Disabled Applicants

The following individuals are eligible for SSI-related Medicaid as categorically needy.

(a) Breast or cervical cancer - Women found to have breast or cervical cancer, including precancerous conditions, screened through the National Breast and Cervical Cancer Early Detection Program and who:

- are under age 65;
- uninsured; and
- otherwise not eligible for SSI-related or ANFC-related Medicaid.

Coverage under this category begins following the screening and diagnosis and continues as long as a treating health professional verifies the woman is in need of cancer treatment services.

(b) Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid except that they meet the criteria below:

(i) Income requirements

Individuals whose income:

- is below 250 percent of the federal poverty level (FPL) associated with the applicable family size; and
- does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings and up to $500 of social security disability insurance benefits (SSDI) of the individual working with disabilities.

Earnings and SSDI shall not be disregarded for applicants with spenddown requirements.

M200.2 SSI-Related Categorically Needy Coverage Groups

M200.24 SSI-Related Medicaid Coverage Groups Open to New Aged, Blind, or Disabled Applicants (Continued)

(b) (Continued)

(ii) Premium requirement

For each month the individual meets all eligibility criteria, coverage under this category begins the first of the month *following the payment of the applicable premium amount listed in the table below.*

Net Household Income FPL	Monthly Premium for Medicaid Group
0 - 185%	$0
> 185% and ≤ 225%	$50
> 225% and ≤ 250% with other insurance that includes hospital and physician coverage	$60
> 225% and ≤ 250% without other insurance	$75

When a single household includes more than one individual eligible for WPWD coverage, the household must pay only the highest applicable premium for coverage of these individuals.

***Italicized* text on this page becomes effective April 1, 2004.**

M231 Types of Resources (Continued)

M231.22 Retirement Funds (see section M232.85)

M231.23 Stocks, Bonds, Mutual Funds, and Money Market Funds

(a) Definitions

Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(i) United States Savings Bonds

(A) Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.

(B) Series I bonds are sold at their full face value and increase in redemption value as interest accrues.

(C) Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

M231.24 Annuities (see section M232.4)

M231.25 Mortgages and Promissory Notes

A mortgage is the pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt. A promissory note is a written promise to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

M231.26 Home Equity Conversion Plans (see section M232.14)

M231 Types of Resources (Continued)

M231.3 Resources Managed by a Third Party

Resources managed by third parties include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the member's behalf without the member's direction.

M231.31 Trusts (see section M232.5 – M232.53)

M231.32 Power of Attorney

Power of attorney means a written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by agents under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

M231.33 Guardian

Guardian means a person or institution appointed by a court in any state to act as a legal representative for another individual, such as a minor or a person with disabilities. Guardianship accounts are presumed to be available for the support and maintenance of the protected individual. Individuals may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

M231.34 Representative Payee

Representative payee means an individual, agency, or institution selected by a court or the Social Security Administration to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of the beneficiary, notify the payor of any event that will affect the amount of benefits the beneficiary receives or circumstances that would affect the performance of the payee responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

M231.35 Fiduciary for a Joint Fiduciary Account (see section M232.71)

M233 Value of Resources Counted Toward the Medicaid Resource Limit (Continued)

M233.24 United States Savings Bonds

This rule applies only to individuals who own or purchase savings bonds for the first time on or after December 1, 2003 and otherwise would be eligible for Medicaid.

The department counts United States savings bonds as a resource beginning on the date of purchase. To establish the value of the bonds, the department uses the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U.S. Bureau of Public Debt's Internet web site at: www.publicdebt.treas.gov/sav/savcalc.htm. Alternatively, the department obtains the value by telephone from a local bank. The following general rules apply to valuation.

(a) Series E and EE bonds are valued at their purchase price.

(b) Series I bonds are valued at their face value.

(c) Series HH bonds are valued at face value.

M302.22 Groups No Longer Eligible for ANFC-Related Medicaid Due to Increased Child Support (Transitional Medicaid)

Medicaid groups who were granted Medicaid but no longer meet the ANFC-related Medicaid eligibility criteria defined above at least partly as a result of collection or increased collection of support on or after August 16, 1984, continue to be eligible for a period of four calendar months if the Medicaid group:

- continues to reside in Vermont; and
- meets the ANFC-related Medicaid criteria in at least three of the six months immediately preceding the month in which such ineligibility begins.

M302.23 Individuals In Institutions

Individuals who would meet the ANFC-related eligibility criteria defined above if they were not in a medical institution are eligible for ANFC-related Medicaid.

M302.24 Individuals Entitled to OASDI and Receiving Cash Assistance in August 1972

Individuals who would meet the ANFC-related eligibility criteria defined above except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), were entitled to OASDI in August 1972, and were receiving cash assistance in August 1972 are eligible for ANFC-related Medicaid. This includes persons who would have been eligible in August 1972 but either had not applied for cash assistance or were in a medical institution or intermediate care facility care facility.

M302.25 Individuals Receiving Child Care Services

Individuals who would meet the ANFC-related eligibility criteria defined above if their work-related child care costs were paid from earnings rather than by a state agency as a service expenditure are eligible for ANFC-related Medicaid.

M302.26 Children Under 18 (Dr. Dynasaur)

Children under age 18 who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their household income does not exceed 300 percent of the federal poverty level (FPL). There is no resource test under this provision.

Premiums *as specified in M150-M150.2* are required for the following individuals within this coverage group. Individuals requesting Dr. Dynasaur with income above 185 percent of the FPL but no more than 225 percent are required to pay a monthly premium of $25 per household before coverage will begin or continue. Those with incomes above 225 percent but no more than 300 percent of the FPL must pay a $35 monthly premium if the family has other insurance that includes hospital and physician coverage and a $70 monthly premium if the family has no insurance besides Dr. Dynasaur.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

Children who are members of federally designated American Indian or Alaskan Native tribes, as designated by the federal Bureau of Indian Affairs do not have to pay a premium if their household income is more than 225% but less than or equal to 300% FPL and they have no other insurance. Abenaki is not a federally designated tribe. If other children in the household are beneficiaries but not members of a federally-designated tribe, then the household is still responsible for the premium.

Children qualifying for Medicaid under Dr. Dynasaur and the Disabled Child in Home Care (DCHC/Katie Beckett) coverage group (see M200.23(d)) may select which of the two sets of rules that they wish to have determine their eligibility. An applicant applying under the DCHC coverage group who is eligible under Dr. Dynasaur shall receive Dr. Dynasaur coverage while the application is pending.

To assist applicants in making a decision between the two coverage groups, the department will provide the applicant with the requirements specific to the two groups, including the service delivery systems used, the process for determining eligibility, the time for processing applications, and the cost-sharing requirements of beneficiaries in each group.

PATH updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds PATH's income maximum, PATH will issue a second increase on April 1.

M302.27 Pregnant Women (Dr. Dynasaur)

Pregnant women who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their family income does not exceed 200 percent of the federal poverty level (FPL), without regard to any change in their Medicaid group's income during pregnancy and during the 60-day post-pregnancy period, which ends on the last day of the month during which the 60th day falls. There is no resource test under this provision.

Although a woman may be granted up to three months retroactive coverage if she was pregnant and met all eligibility criteria, she is not eligible for the 60-day post-pregnancy period if she applies after her pregnancy has ended. However, she may be eligible after her pregnancy ends based on another categorical criterion or coverage provision and a different income test.

Pregnant women with income above 185 percent of the FPL but no more than 200 percent are required to pay a monthly premium of $25 for coverage.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

PATH updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds PATH's income maximum, PATH will issue a second increase on April 1.

M302.28 Other ANFC-Related Categorically Eligible Coverage Groups

(a) (Newborns) A child born to a woman eligible for and receiving Medicaid on the date of the child's birth is categorically eligible for ANFC-related Medicaid. The child is deemed eligible for two months after birth. The child remains eligible for up to twelve months if the child remains in the same household as the mother and the mother remains eligible, or would be eligible if pregnant. Children are considered members of their mother's household if they are continuously hospitalized after birth, unless the mother has legally relinquished control or abandoned them.

(b) (Adoption or Foster Care) Children under the age of 21 living in Vermont for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made (by any state) under title IV-E of the Act are automatically eligible for ANFC-related Medicaid. Committed children in the custody of SRS not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

M670 Eyeglasses and Vision Care Services

M670.1 Definition

Eyeglasses and vision care services are those services requiring the application of theories, principles and procedures related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. This definition is consistent with the federal definition of services found at 42 CFR §440.60(a), 440.120(d), and 441.30.

M670.2 Eligibility for Care

Coverage of eyewear is limited to beneficiaries under the age of 21. Vision care services are provided to beneficiaries of any age.

M670.3 Covered Services

Eyeglasses and vision care services that have been pre-approved for coverage are limited to:

- one comprehensive visual analysis and one interim eye exam within a two-year period;
- diagnostic visits and tests;
- dispensing fees (all dispensing fees for beneficiaries age 21and older are suspended indefinitely);
- a prescription for frames and lenses every two years (all frames and lenses for beneficiaries age 21 and older are suspended indefinitely);
- contact and special lenses, when medically necessary and with prior approval (all contact and special lenses for beneficiaries age 21 and older are suspended indefinitely); and
- other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

M670.4 Conditions for Coverage

Coverage is limited to one pair of glasses every two years per beneficiary. Earlier replacement is limited to the following circumstances.

When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity being compromised.)

2602 Eligibility Due to a Catastrophic Situation

Applicants with an emergency need attributable to a catastrophic situation (2602.1) may qualify for GA to address that need, provided that they meet the eligibility criteria in 2602-2604 and payment conditions in 2611-2627. Applicants seeking help for an emergency medical need shall not be eligible for GA to address that need if they have been denied or lost health insurance sponsored by the state or federal government for specified reasons (see 2602(4)).

To qualify for such assistance, applicants must meet all of the following eligibility criteria:

1. They must have an emergency need attributable to a catastrophic situation, as defined in 2602.1.
2. They must have exhausted all available income and resources.
3. They must explore and pursue or have explored and pursued all alternatives for addressing the need, such as family, credit or loans, private or community resources, and private or government-sponsored health insurance. Before the department will determine eligibility for GA payment for vision services or items, the applicant must pursue or have pursued assistance from the Vermont Association for the Blind, the Lions Club and other service organizations, school-related health programs, and other child development programs, if applicable.
4. *Beginning April 1, 2004, if seeking assistance for a medical need, at the department's most recent eligibility determination they must not have been denied or lost government-sponsored health insurance that would have covered the current need because of either or both of the following reasons:*

    - *they failed to pay a premium for the government-sponsored health insurance, or*
    - *they failed to comply with any administrative eligibility requirement necessary to be covered by the government-sponsored health insurance.*

For purposes of GA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance.

Eligibility workers shall explain to applicants that they are expected to take steps to avoid or resolve emergencies in the future without GA and that they will be asked to demonstrate that they have done so if they reapply. This explanation shall be documented in the applicant's case record.

Subsequent applications must be evaluated in relation to the individual applicant's potential for having resolved the need within the time which has elapsed since the catastrophe to determine whether the need is now caused by the catastrophe or is a result of failure on the part of the applicant to explore potential resolution of the problem.

The department shall not apply an income test or resource exclusions in determining eligibility due to a catastrophic situation.

***Italicized* text on this page becomes effective April 1, 2004.**

2620 Medical Care

The types of medical care covered for applicants meeting the eligibility criteria in 2602, 2602.1, and 2602.3 for eligibility due to a catastrophic situation and the general eligibility criteria in 2603 and 2604 are limited to:

- physician services (as further limited in 2621),
- dental services, (as further limited in 2622),
- vision services and items (as further limited in 2623),
- prescription drugs (as specified in 2624),
- medical supplies (as defined and further limited in 2625),
- durable medical equipment (as defined and further limited in 2626), and
- ambulance transportation (as further limited in 2627).

Other types of medical care (e.g., hospital services, other transportation, visiting nurses*) and, beginning April 1, 2004, payment of premiums for private or government-sponsored health insurance are not covered. For purposes of GA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance.* Routine examinations and treatment are not covered by GA because they do not address emergency medical needs.

For applicants who are beneficiaries under Medicaid, VHAP or another government-sponsored health care coverage program, the prior authorization requirements for that program, if any, apply equally to coverage for medical care under GA. GA payment is limited to providers enrolled in the Medicaid program.

The department shall pay for medical care with GA only if application is made within the following time frames:

- before receipt of the care,
- up to 30 days after the original billing date for care received, or
- within 30 days from the notice date on denial of eligibility by Medicaid, VHAP, or other government-sponsored health care coverage for reasons other than those specified in 2602 (4).

When application is made within 30 days from the notice date on denial of eligibility by Medicaid, VHAP, or other government-sponsored health care coverage for reasons other than those specified in 2602 (4), the application date for health care coverage shall be considered the application date for GA, and the GA application shall cover the full period during which the application for health care coverage was pending.

The department shall determine the applicant's eligibility for GA payment of medical care based on the applicant's circumstances on the date of application, not on the date the care is received.

Requests for payment from providers of medical care shall not be considered applications for GA.

***Italicized* text on this page becomes effective April 1, 2004.**

2801 Definitions (Continued)

Transient An individual who does not intend to establish a permanent residence in Vermont.

2802 Eligibility Due to a Catastrophic Situation

Applicants with an emergency need attributable to a catastrophic situation (see below) may qualify for EA to address that need, provided that they meet the eligibility criteria in 2802-2804 and payment conditions in 2811-2820. Applicants seeking help for an emergency medical need shall not be eligible for EA to address that need if they have been denied or lost health insurance sponsored by the state or federal government for specified reasons (see 2802(4)).

To qualify for such assistance, applicants must meet all of the following eligibility criteria:

1. They must have an emergency need attributable to a catastrophic situation (see below).

2. They must have exhausted all available income and resources.

3. They must explore and pursue or have explored and pursued all alternatives for addressing the need, such as family, credit or loans, private or community resources, and private or government-sponsored health insurance. Before the department will determine eligibility for EA payment for vision services or items, the applicant must pursue or have pursued assistance from the Vermont Association for the Blind, the Lions Club and other service organizations, school-related health programs, and other child development programs, if applicable.

4. Beginning April 1, 2004, if seeking assistance for a medical need, at the department's most recent eligibility determination they must not have been denied or lost government-sponsored health insurance that would have covered the current need because of either or both of the following reasons:

- *they failed to pay a premium for the government-sponsored health insurance, or*
- *they failed to comply with any administrative eligibility requirement necessary to be covered by the government-sponsored health insurance.*

For purposes of EA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance.

Eligibility workers shall explain to applicants that they are expected to take steps to avoid or resolve emergencies in the future without EA and that they will be asked to demonstrate that they have done so if they reapply. This explanation shall be documented in the applicant's case record.

2802 Eligibility Due to a Catastrophic Situation (Continued)

Subsequent applications must be evaluated in relation to the individual applicant's potential for having resolved the need within the time which has elapsed since the catastrophe to determine whether the need is now caused by the catastrophe or is a result of failure on the part of the applicant to explore potential resolution of the problem.

The department shall not apply an income test or resource exclusions in determining eligibility due to a catastrophic situation.

For the purposes of this section, catastrophic situations are limited to the following situations:

a. Death of a spouse or minor dependent child; or

b. A court-ordered or constructive eviction due to circumstances over which the applicant had no control. An eviction resulting from intentional, serious property damage caused by the applicant, other household members or their guests; repeated instances of raucous and illegal behavior which seriously infringed on the rights of the landlord or other tenants of the landlord; or intentional and serious violation of a tenant agreement is not considered a catastrophic situation. Violation of a tenant agreement shall not include nonpayment of rent unless the tenant had sufficient financial ability to pay and the tenant did not use the income to cover other basic necessities or did not withhold the rent pursuant to efforts to correct substandard housing.

   Constructive eviction is defined as any disturbance caused by a landlord or someone acting on his/her behalf, which makes the premises unfit for occupation. The motive for the disturbance, which may be inferred from the act, must have as its intent the eviction of the occupant. No intent needs to be considered when heat, utilities or water is not provided within a reasonable period of time and there is an agreement to furnish these items, but pursuit by the applicant of a legal resolution of these Vermont health regulation offenses is expected.

c. A natural disaster such as flood, fire or hurricane; or

d. An emergency medical need (as defined at 2602.3), or

e. A child welfare emergency, as determined by the Department of Social and Rehabilitation Services (SRS), requiring protective, family preservation or support services.

2820 Medical Care

Medical care is limited to the types of care described in General Assistance Rule sections 2620 through 2626 for events described in 2602. For purposes of the Emergency Assistance Program the type of medical care covered is limited to physician care, dental care, eye care, pharmacy care, and ambulance transportation. Other types of medical care (e.g., other transportation, visiting nurses, etc.) *and, beginning April 1, 2004, payment of premiums for private or government-sponsored health insurance* are not paid for under the EA program.

The following eligibility criteria must be met:

- The applicant meets the criteria in 2802 (Catastrophic Situations).
- The Medical Consultant in the Medicaid Division may be consulted by the Eligibility Specialist when the emergency nature of a need is questionable.

The Medical Consultant is also consulted when a medical need requires prior authorization as specified in sections 2611 through 2626.

- The applicant is not eligible for Medicaid; or the expense cannot be covered by Medicaid.
- The medical care is rendered in Vermont to an individual who has not entered Vermont for the purpose of obtaining medical care.

2820.1 Payment

A Department issued vendor must accompany provider bills.

Payment to providers may not exceed the amount set forth in the fee schedule used in the Vermont Medicaid Program.

The Medical Consultant in the Medicaid Division will review all questionable claims to confirm the emergency nature of the treatment and to establish that the amount charged is in accord with the usual and customary charge.

2820.2 Balance Billing

Vermont law (33 V.S.A. 6501-6508) prohibits charging or collecting from the recipient any amount in excess of the reasonable charge for the service. The reasonable charge for EA services is the Medicaid Fee Schedule.

***Italicized* text on this page becomes effective April 1, 2004.**

3202 Coverage

Individuals are enrolled in this program and receive assistance in purchasing covered drugs from participating pharmacies after meeting all eligibility criteria *and paying the required* premium.

The department's payment for covered pharmaceuticals shall be based upon current Medicaid payment and dispensing policies.

3202.1 Drugs

"Drug" means a drug that may not be dispensed unless prescribed by a licensed physician. A drug shall always be the lowest cost brand available to the pharmacist unless the physician writing the prescription specifies otherwise. The term includes insulin, an insulin syringe and an insulin needle. The term excludes:

- a drug determined less than effective under the federal Food, Drug and Cosmetics Act;
- a drug within therapeutic classifications primarily associated with the treatment of acute medical conditions; and
- a central nervous system agent other than:

    - agents used for treatment of convulsive disorders;
    - nonsteroidal anti-inflammatory agents for arthritis; and
    - agents used primarily for control of psychotic conditions diagnosed under current classifications of the Diagnostic Statistical Manual.

Lists of covered and excluded drugs are maintained and periodically updated by the department and available upon request.

For beneficiaries whose VScript group income is greater than 175 percent but no greater than 225 percent of the federal poverty level coverage is limited to drugs dispensed by participating pharmacies of manufacturers that as a condition of participation in the program, have signed a rebate agreement with the commissioner.

***Italicized* text on this page becomes effective April 1, 2004.**

3202.2 Participating Pharmacy

"Pharmacy" means a retail or institutional drug outlet licensed by the Vermont state board of pharmacy pursuant to chapter 36 of Title 26, or by an equivalent board in another state, in which prescription drugs are sold at retail and which has entered into a written agreement with the state to dispense drugs in accordance with the provisions of this program. To enroll in VScript, a provider must:

- satisfactorily complete and submit to the Department the standard enrollment form;
- submit with the enrollment form a signed provider agreement which sets forth the standard provisions and assurances required of participating providers;
- conform to the standards of the Vermont State Board of Pharmacy and other Federal and State statutes and regulations applicable to the dispensing of prescription drugs to the general public;
- agree to provide reasonable access to records necessary to comply with the provisions for program review set forth in the Provider Agreement;
- never deny services to, or otherwise discriminate against, a recipient on the basis of race, color, sex, age, religious preference, national origin or handicap; and
- take appropriate steps to prevent misutilization of prescription drugs, with special concern for the potentially dangerous interaction of two or more prescription drugs from different prescribers.

3202.3 Dispensing

A drug may be dispensed by a participating pharmacy to a beneficiary upon verification of enrollment, provided such dispensing is pursuant to and in accordance with any contractual arrangement that the department may enter into or approve for the group discount purchase of drugs. Group discount purchase of drugs means contractual arrangements for the procurement and/or distribution of drugs designed to contain costs which include but need not be limited to volume purchasing through manufacturers, wholesalers or retailers, manufacturers' rebates, or mail order delivery. Contracts will be awarded pursuant to guidelines established by the Agency of Administration in Bulletin 3.5 and subsequent issuances. Prior to the beginning of each fiscal year, the Commissioner shall determine the most practical and cost-effective method of purchasing VScript covered drugs. When a person or business located in Vermont and employing citizens of this state has submitted a bid for the group discount purchase of drugs and has not been selected, the Commissioner of the Department shall record the reason for nonselection. The Commissioner's report shall be a public record available to any interested person. All bids or quotations shall be kept on file in the Commissioner's Office and open to public inspection.

The department shall monitor enrollment in the VScript program on a monthly basis, and shall limit enrollment in the program so that expenditures do not exceed the appropriation available for the program in any fiscal year.

3203 Cost Sharing Requirements

All VScript beneficiaries must pay monthly premiums *as specified in M150 through M150.2 to be enrolled in a VScript coverage group.*

The following premium amounts apply to VScript.

VScript Group Income	Coverage Group	Monthly Program Fee, Per Individual
> 150% ≤ 175% FPL	VScript	$17
> 175% ≤ 225% FPL	VScript Expanded	$35

***Italicized* text on this page becomes effective April 1, 2004.**

3204 Process

3204.1 Application

Between January 1 and June 15, applicants may complete the VScript application form provided in the state income tax return. The application form must be completed legibly and accurately with all questions answered fully, the rights and responsibilities statement read, proper signatures of applicant and applicant's spouse, dated, and submitted to the Department of Taxes on or before June 15. The Department of Taxes shall perform such income verification as is requested by the Secretary and transmit applications to the Department.

By signing/marking the rights and responsibilities statement on the application form, the applicant authorizes the Department to verify any information on the form, such as by contacting the Internal Revenue Service or the Social Security Administration.

Applicants may also access the VScript program anytime during the year by filing a VHAP-Pharmacy or Medicaid application. Applicants found ineligible for VHAP-Pharmacy or Medicaid shall have their eligibility determined for VScript and enrolled in VScript, *upon payment of the required premium* provided all other eligibility criteria are met.

Individuals have the responsibility to:

- notify the Department of a change of address;
- notify the Department whenever they become eligible for another plan of assistance or insurance; and
- notify the Department of a change in income or household size after an application has been submitted but before eligibility begins.

3204.2 Application Decision

An eligibility decision must be made within 30 days of the date the application is received by the Health Access Eligibility Unit or a Department of PATH district office. An applicant with countable income over the income test shall be denied and may reapply at any time.

Each applicant for the VScript program shall be given written notice of the decision on his/her application. All notice letters shall explain the decision and why it was made and how to appeal the decision if not satisfied.

The department will issue each enrolled beneficiary an identification card. This card shall contain the beneficiary's name and identification number. The identification card must be presented to a provider at the time of purchase. Replacement cards shall be issued by the department.

***Italicized* text on this page becomes effective April 1, 2004.**

3204.3 Period of Eligibility and Enrollment

A. Eligibility

If VScript eligibility begins on or after July 1 but no later than December 31, VScript eligibility continues through June 30 of the next year. If VScript eligibility begins on or after January 1 but no later than June 30, VScript eligibility continues through June 30 of the following year.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, pays all required premiums and complies in a timely manner with review requirements. An individual who fails to pay required premiums or fails to comply in a timely manner with review requirements shall receive a termination notice mailed at least 11 days before the termination date.

Medicaid or VHAP-Pharmacy beneficiaries who lose eligibility in those programs will be enrolled in VScript upon payment of required premium, provided all other eligibility criteria are met.

B. Enrollment

Once eligibility for VScript is determined *and required premiums are received by the department, according to rules specified at M150-M150.2* beneficiaries are enrolled beginning on the first day of the month following receipt of full premium payment through June 30 unless they are disenrolled at the end of the month following a notice mailed at least 11 days before the disenrollment date because they:

- fail to pay required premiums;
- establish residence outside of Vermont;
- become eligible for full or partial coverage of prescription drugs under another plan of assistance or insurance;
- are incarcerated;
- voluntarily withdraw;
- are found to have been ineligible on the date coverage began;
- are no longer in contact with the department of PATH and have no known address; or
- die.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

***Italicized* text on this page becomes effective April 1, 2004.**

3204.3 Period of Eligibility and Enrollment

B. Enrollment (Continued)

If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in section M150.1(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The department will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until the department receives the required verification and premium amounts due.

If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition (see Rule M104).

3204.4 Payment Methodology

Participating pharmacies shall dispense a drug upon verification of a beneficiary's enrollment. The pharmacy shall collect the charge for the drug from the department.

3204.5 Right to Appeal

Individuals who have applied for or received VScript may appeal any decision of the department relating to their coverage and may request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision.

When beneficiaries appeal a decision to end or reduce VScript coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary has requested a hearing before the effective date of the change and has paid in full any required premiums. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved.

***Italicized* text on this page becomes effective April 1, 2004.**

3204.3 Period of Eligibility and Enrollment

3204.5 Right to Appeal (Continued)

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141). Beneficiaries who waive their right to continued benefits will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal process in any case in which the Human Services Board reverses the decision.

Notice of an adverse change in cost sharing requirements must be mailed to individuals at least 10 days before the effective date.

3300 Introduction

Legislative Act 14, authorizing and supporting the Vermont Health Access Plan, was adopted by the Vermont General Assembly and signed into law by the Governor on April 12, 1995. The Vermont Health Access Plan extends a pharmacy benefit and vision care services to low-income disabled and elderly Vermonters to assist them to purchase the prescription medicines that maintain their health and prevent unnecessary health problems. Vision care services do not include eyewear.

The policies which follow describe this coverage group called VHAP-Pharmacy.

3301 Eligibility

An individual must meet all of the following requirements (3301.1 - 3301.74) to be found eligible for this program.

3301.1 Age

An individual qualifying on the basis of age must be at least 65 years of age on the date the application is filed.

3301.2 Disability

An individual qualifying on the basis of disability must be receiving disability benefits from Social Security (OASDI) or have Medicare coverage. Individuals in receipt of Railroad disability benefits must have Medicare coverage in order to be considered disabled.

3301.3 Uninsured

Individuals meet the uninsured requirement if they do not have any plan, including VHAP-Limited, which pays or reimburses, either in whole or in part, with the exception of VScript, Healthy Vermonters, or Medicare, their prescription drug expenses.

3301.4 Citizenship

An individual meets the citizenship requirement if he/she meets one of these two criteria:

(1) He/she is a native-born or naturalized U.S. citizen. For purposes of qualifying as a United States citizen, the United States, as defined in the Immigration and Nationality Act, includes the 50 States, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island also are regarded as United States citizens for purposes of VHAP-Pharmacy.

3302.1 Application

An application submitted through the Vermont state income tax process within the usual January 1 to June 15 application period shall be considered a valid application for VHAP-Pharmacy. Applicants determined eligible for VHAP-Pharmacy shall be offered enrollment.

Individuals who did not file through the state income tax process must file an application for VHAP-Pharmacy with PATH and provide information about his/her situation relevant to the tests for eligibility (Section 3301). Applications are date-stamped to assure that earlier applications are acted upon first.

An applicant must furnish his/her social security number or apply for a social security number unless he/she substantiates he/she is a member of a religious organization that objects to the use of a social security number. An applicant who substantiates membership in such an organization shall be given an alternate identification number.

Verification of the information provided is not generally required of the applicant or beneficiary unless it is questionable, verification is outstanding for another benefit program, or the applicant or beneficiary has refused to provide a social security number because of a religious objection. Social security numbers are used to verify information through tape matches. Clients are notified on the application form of the verification actions the department may take, including the use of verification obtained for other department programs, randomly selected quality control reviews, and the penalties for fraudulent reporting of their situation.

Individuals who are found eligible for VHAP-Pharmacy and subsequently become ineligible for that program, due to a change in their circumstances or other program changes, shall be considered for eligibility in the VScript or Healthy Vermonter's program.

3302.2 Application Decision

An eligibility decision must be made within 30 days of the date the application is received by PATH. An applicant with countable income over the income test shall be denied and may reapply at any time.

An applicant will be sent a notice regarding the action being taken on his/her application . An applicant who is denied will be sent a denial notice that includes the reason for the denial and the applicant's appeal rights.

Individuals offered VHAP-Pharmacy coverage may apply for any other health care assistance offered by the department at any time.

3302 Eligibility Process

3302.3 Period of Eligibility and Enrollment

A. Eligibility

Eligibility criteria are described in rules 3301.1 – 3301.74.

If VHAP-Pharmacy eligibility begins on or after July 1 but no later than December 31, eligibility continues through June 30 of the next year. If VHAP-Pharmacy eligibility begins on or after January 1 but no later than June 30, eligibility continues through June 30 of the following year.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, pays all required premiums, and complies in a timely manner with review requirements. An individual who fails to pay required premiums or fails to comply in a timely manner with review requirements shall receive a termination notice mailed at least 11 days before the termination date.

B. Enrollment

Once eligibility for VHAP-Pharmacy is determined *and required premiums are received by the department, according to the rules specified at M150-M150.2*, beneficiaries are enrolled beginning on the first day of the month following receipt of full premium payment through June 30 unless they are disenrolled at the end of the month following a notice mailed at least 11 days before the disenrollment date. Disenrollment shall occur whenever beneficiaries:

- fail to pay the required premium;
- are incarcerated;
- become eligible for another plan of assistance or insurance that provides any payment or reimbursement of prescription costs;
- move out-of-state;
- voluntarily withdraw;
- are found to have been ineligible on the date coverage began;
- are no longer in contact with the Department and has no known address;
- die.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

***Italicized* text on this page becomes effective April 1, 2004.**

3302 Eligibility Process

3302.3 Period of Eligibility and Enrollment

B. Enrollment (Continued)

If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in section M150.1(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The department will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until the department receives the required verification and premium amounts due.

If the health condition related to this medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.

3302.4 Identification Document

Each individual in the household enrolled in VHAP-Pharmacy is provided with an identification card which includes the name and identification number.

3302.5 Application for Other Benefits

Individuals who wish to apply for traditional Medicaid or other benefits available through PATH must file an application as required under those programs.

3302 Eligibility Process

3302.6 Right to Appeal

The department shall provide individuals with notice whenever they are found ineligible for the VHAP-Pharmacy program or when the services they may receive under the VHAP-Pharmacy program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

When beneficiaries appeal a decision to end VHAP-Pharmacy coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary has requested a hearing before the effective date of the change and has paid in full any required premiums. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who appeal the amount of their premium and win will be reimbursed by the department for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries who waive their right to continued benefits will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal period in any case in which the Human Services Board reverses the decision.

3302.7 Beneficiary Fraud Investigation

A person, who knowingly gives false or misleading information or holds back needed information in order to obtain VHAP-Pharmacy benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When PATH learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

3303 Payment Conditions

3303.1 Cost Sharing

The department requires all beneficiaries to pay a monthly premium of $13 to enroll in the VHAP-Pharmacy program. The premium payment system applicable to VHAP-*Pharmacy is described in M150 through M150.2.*

3303.2 Lower of Price for Ingredients Plus Dispensing Fee or Charge

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 3303.3) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

3303.3 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).

a. For multiple-source drugs, the price for ingredients will be the lowest of:

   1. an amount established as the upper limit derived from a listing issued by CMMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or
   2. an amount established as the upper limit by the Office of Vermont Health Access, or
   3. the Average Wholesale Price (AWP).

b. For "other" drugs, the price for ingredients will be 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).

***Italicized* text on this page becomes effective April 1, 2004.**

3305 Benefit Coverage (Continued)

- insulin and other diabetic supplies, including:
  - glucose strips and tablets, and
  - needles and syringes;
- one comprehensive visual analysis and one interim eye exam within a two-year period, and
- diagnostic visits and tests.

Exclusions

No benefits are provided for:

- refills beyond the original and five refills per script up to one year maximum;
- multi-vitamins;
- hair replacement therapies;
- drugs, and contraceptive medications, devices or supplies for which there is no prescription;
- drugs for the sole purpose of fertility; and
- over-the-counter drugs and medicinals.

3402 Eligibility Process

3402.5 Requirement to Report Changes

Applicants and beneficiaries must report changes in income and household composition within 10 days after learning of the change. They must also notify the department within 10 days after they:

- become eligible for insurance or other assistance covering prescription drugs;
- no longer meet state residency requirements (3401.3);
- are incarcerated; or
- have a change of address.

3402.6 Identification Document

The department shall provide each eligible Healthy Vermonters individual with an identification card. This identification card may be used only at participating pharmacies as defined at 3403.5.

3402.7 Application for Other Benefits

Individuals accepted into the Healthy Vermonters program may apply for the traditional Medicaid program or any other health care program at any time.

Individuals who wish to apply for traditional Medicaid or other benefits available through the department must file an application as required under those programs.

3402.8 Right to Appeal

The department will provide applicants and beneficiaries with notices whenever they are found ineligible for the Healthy Vermonters program or when the services they may receive under the Healthy Vermonters program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

When beneficiaries appeal a decision to end Healthy Vermonters coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary has requested a hearing before the effective date of the change.

3402 Eligibility Process

3402.8 Right to Appeal (Continued)

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries who waive their right to continued benefits will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal period in any case in which the Human Services Board reverses the decision.

3402.9 Beneficiary Fraud Investigation

A person who knowingly gives false or misleading information or holds back needed information in order to obtain Healthy Vermonters benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When the department learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the beneficiary. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

4001.9 Cost-Sharing Requirements

4001.91 Premium

Individuals meet this requirement when they have paid *any required premium as specified in M150 - M150.2.* The amount of the premium for each individual increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

Income Maximums	Monthly Premium per Individual
> 50% but ≤ 75% FPL	$10.00
> 75% but ≤ 100% FPL	$35.00
> 100% but ≤ 150% FPL	$45.00
> 150% but ≤ 185% FPL	$65.00

4001.92 Copayment

There is a copayment requirement of $25 per medically necessary hospital emergency room visit, as defined in M103.3(13) and (37).

4002 Eligibility and Enrollment Process

4002.3 Period of Eligibility and Enrollment

A. Eligibility

The VHAP eligibility criteria are described in rules 4001.1 – 4001.91.

B. Enrollment

If all eligibility criteria are met, the individual shall be enrolled in the VHAP program on the first day of the month after the department has received and processed the premium.

Once enrolled, coverage continues until the scheduled eligibility review unless beneficiaries are disenrolled from the program following a notice mailed at least 11 days before the termination date because they:

- have a change in income that results in income over the applicable income test;
- have a change in the household size that results in income over the income test for the new household size;
- lose eligibility as a student;
- are incarcerated;
- are admitted to a long-term care facility, such as a nursing home, a free-standing psychiatric facility or an ICF/MR facility for longer than 30 days;
- acquire insurance that includes both hospital and physician coverage that has no disqualification period for a pre-existing condition, or has a disqualification period that has ended or that has lasted for one year or more;
- obtain Medicare coverage;
- move out-of-state;
- voluntarily disenroll from the program;
- are found to have been ineligible on the date coverage began;
- are no longer in contact with the department and have no known address;
- fail to provide verification requested for another program if it pertains to an eligibility factor for the VHAP program;
- fail to pay any required premiums; or
- die.

The notice will inform beneficiaries of their appeal rights and provide them with information about other health care assistance, including how and where to apply.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

4002 Eligibility Process

4002.3 Period of Eligibility and Enrollment (Continued)

Individuals who have been disenrolled from the VHAP program must file a new application for the program before eligibility may be re-established.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to comply timely with review requirements and paying any required premium shall receive a termination notice mailed at least 11 days before the termination date. A failure to comply timely may result in a gap in coverage.

4002.31 VHAP-Limited Coverage

Individuals applying for VHAP will receive limited coverage, as described in the Medicaid Procedures Manual section P-4003, at no cost between the date the department determines eligibility and the date full coverage begins. Full coverage begins on the first day of the month after the department has processed the full premium payment as specified at M150-M150.2. Individuals who do not pay the full premium by the due date are responsible for all bills incurred during that limited coverage period. The notice of eligibility the department sends individuals describes the limited coverage and includes a warning that failure to pay the full premium by the due date will result in no coverage for any bills incurred since the date of eligibility. Individuals will also be notified of the requirement that they must choose a primary care provider by the premium due date, or one will be chosen for them by the department.

When an individual's coverage is cancelled in whole or in part due to nonpayment of the premium and the individual attempts to reenroll within twelve months, retroactive coverage will be provided only if the individual meets one of the five exceptions listed below.

(A) The individual or spouse had employer-sponsored insurance that terminated because of:

- *loss of employment;*
- *death of the principal insurance policyholder;*
- *divorce or dissolution of a civil union;*
- *no longer qualifying as a dependent under the plan of a parent or caretaker relative; or*
- *no longer qualifying for COBRA, VIPER or other state continuation coverage.*

4002 Eligibility Process

4002.31 VHAP-Limited Coverage (Continued)

(B) The individual or spouse had university-sponsored insurance that terminated because they graduated, took a leave of absence, or otherwise terminated their studies. Students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, however, if they:

- *have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or*
- *are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.*

(C) The individual's household income dropped below 75% of FPL if their household income, after allowable deductions, for households of the same size.

(D) The individual established residence in another state for more than 30 days and subsequently returned to Vermont.

(E) The individual was medically incapacitated during the period when premium payments were due.

The department must receive verification of medical incapacity.

Medical incapacity means severe memory loss or an immediate and serious health condition limited to inpatient hospitalization throughout the period premium payments were due that prevented the beneficiary from paying the premium timely. The department must receive verification of medical incapacity. If the health condition related to this medical incapacity is expected to continue or reoccur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.

4002.32 VHAP Managed Health Care System

If all eligibility criteria (4001.1 - 4001.91) are met, individuals shall be enrolled in the managed health care system, with full VHAP coverage, no later than the first of the month after the department has received and processed the full premium payment. If a choice of primary care provider is not made by the premium due date, a primary care provider will automatically be assigned.

4002.4 Identification Document

Each individual in the household who is enrolled is provided with an identification card.

4002 Eligibility Process

4002.5 Application for Medicaid

Individuals who wish to apply for the Medicaid program must file an application as required under that program.

Applicant will be advised that retroactive benefits are only available through the traditional Medicaid program.

Individuals accepted into the VHAP program may apply for the traditional Medicaid program at any time. Individuals required to meet a spenddown for Medicaid may use VHAP premiums and cost sharing to meet their spenddown. Individuals who apply for Medicaid and request reimbursement are reimbursed for any cost-sharing expenses they paid during their participation in the VHAP program to the same extent as other traditional Medicaid recipients are reimbursed.

VHAP enrollees who become pregnant will be notified by the department that they are eligible for traditional Medicaid effective the first of the month in which they advised the department of this change in status. They will be notified that they are eligible for the traditional Medicaid benefits and, depending on their income, of any premium requirements. They will also be notified that they are eligible for up to three months' retroactive benefits under the traditional Medicaid program if they were pregnant and have unpaid bills from that period. Individuals who request reimbursement are reimbursed for any cost-sharing expenses they paid during their participation in the VHAP program to the same extent as other traditional Medicaid recipients are reimbursed.

4002 Eligibility Process

4002.6 Right to Appeal

Applicants and beneficiaries shall be provided by the department with notices whenever an individual is found ineligible for the VHAP program or when the services they may receive under the VHAP program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VHAP coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary has requested a hearing before the effective date of the change and has paid in full any required premiums. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who appeal the amount of their premium and win will be reimbursed by the department for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at M141).

Beneficiaries who request a hearing after the effective date of termination will not receive continued benefits but the department will reimburse out-of-pocket expenses provided during the appeal period in any case in which the Human Services Board reverses the department’s decision.

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

See 4003.24 for rights to appeal managed health care decisions or disenrollment from a plan.

4002.7 Beneficiary Fraud

An individual who knowingly gives false or misleading information or holds back needed information to obtain VHAP benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When the department learns that fraud may have been committed, it will investigate the case with respect to confidentiality and the legal rights of the recipient. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

4003 Benefit Delivery Systems

4003.1 Benefits

A. Services Requiring Plan Referral (Continued)

- mental health and chemical dependency services;

  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.

- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months.

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- eyeglasses furnished through PATH's sole source contractor (coverage of all eyewear is suspended indefinitely);
- family planning services (defined as those services that either prevent or delay pregnancy).